

In those cases in which the assigned prospective rate of a facility falls below the new aggregate ceiling maximum, the Department of Human Services can consider the granting of a prospective rate that reflects demonstrated cost increases in excess of the rate that has been established by the application of the percentage increase. In order to qualify for such a rate increment, demonstrated increased costs must be a result from:

- a. Demonstrated errors made during the rate determination process,
- b. Significant increases in operating costs resulting from the implementation of new or additional programs, services or staff specifically mandated by the Rhode Island Department of Health,
- c. Significant increases in operating costs resulting from capital renovations, expansion, or replacement required for compliance with Fire Safety Codes and/or Certification requirements of the Rhode Island Department of Health, or,
- d. Significant increases in Workers Compensation and/or Health Insurance premiums which cannot be accommodated within the facility's assigned aggregate per diem rate will be allowed a rate increment, if cost justified, so long as the new assigned per diem rates in the Labor Related Expenses cost center and in the Management Related Expenses cost center do not exceed two-percent (2%) of said cost center ceilings, or,
- e. Extraordinary circumstances, including, but not limited to, acts of God, and inordinate increases in energy costs (e.g., federal BTU tax, regional or national energy crisis). Inordinate increases in energy costs will be immediately reflected in increased rates above the energy cost center ceiling maximum. Provided, however, that such increases will be rescinded immediately upon cessation of the extraordinary circumstance.

Initial requests for prospective rate adjustments in excess of those that would be established through application of established percentage increase, will first be reviewed by the Rate Setting Unit within the Center for Adult Health within the Department of Human Services. This Unit will be empowered to grant such variances, provided that the facility involved meets the above criteria and provides all the necessary data.

Requests for rate increments will be limited to one request per annum per facility for the factors specified in items (b) (c) and (d) above. However, additional requests involving a recurring per diem increase in excess of one percent of the facility's previously assigned aggregate per diem rate will also be reviewed. Before a facility files for a rate increment, increases in operating costs addressed in (b) (c) and (d) above must have been incurred

for at least a three-month period in order to establish proof of such increase.

All costs, including salaries, must be absorbed within these group ceilings. The total ceiling maximum will be the sum total of the cost center ceilings.

f. In addition to the above appeal requests, a facility may qualify for a rate increment adjustment, as determined by the department, in accordance with this subsection:

(a) The facility is located in a federally designated Enterprise Community;  
and

(b) The facility is incurring allowable costs in one or more cost centers in excess of the allowable maximum for such cost center(s); and

(c) The facility files a written request for a rate increment with the department

which must include the following documentation:

- i. A cost containment and revenue enhancement plan; and
- ii. A cost report for the most recently completed six (6) months of operations; and
- iii. Such other documents as may be requested by the department.

The department shall review the written request and may grant a rate increment adjustment to become effective not earlier than the month the request was filed which:

1. may result in a per diem rate which shall not exceed the aggregate of all cost center maximums, plus the per diem rate to recognize reimbursement for the health care provider assessment in account #8470; and

2. will be limited for a period not to exceed twenty-four (24) consecutive months; and the facility may reapply for a rate increment adjustment under this subsection for a period of twenty-four (24) consecutive months following the month of expiration or termination of an approved rate increment adjustment; and

3. subject to the aggregate limit in (1) above, may recognize reasonable and necessary costs incurred by the facility to achieve the cost containment/revenue enhancement plan approved by the department; and

4. will be established for an initial six (6) month period, and may be extended and adjusted by the department for an additional six (6) month periods (but not to exceed the overall maximum twenty-four (24) month limit); and

5. will be subject to continuing review and monitoring by the department and such terms and conditions to be specified by the department in a rate

increment approval letter (for initial and extended periods) to the facility.

Rate adjustments granted as a result of a request filed within 120 days after the costs were first incurred will be made effective retroactively to the date such costs were incurred. However, any adjustments granted as a result of requests filed beyond 120 days after the costs were first incurred will be effective on the first day of the month following the filing of the request.

## PAYMENTS

The State of Rhode Island reimburses a provider monthly for Medicaid patient days times the assigned prospective per diem rate. This also applies to State only days.

The State of Rhode Island reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

In determining the number of days for which payment may be made the date of admission is counted, however the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under State General Law Section 40-8.2-3 and Federal regulations, subsidy for patient care by either the patient, relatives or friends to the facility in any manner is prohibited.

## RECORDKEEPING

STATE <u>Rhode Island</u>	A
DATE REC'D _____	
DATE APPV'D <u>9/14/04</u>	
DATE EFF <u>9/1/04</u>	
HCFA 179 _____	

**Adequacy of Cost Information**

Providers of Long Term Care under the State Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable to substantiating the reasonableness of specific reported costs. Records include all ledgers, books and source documents (invoices, purchase orders, time cards or other employee attendance data, etc.). All records must be physically maintained within the State of Rhode Island.

**Census Data**

Statistical records supporting both Medicaid and total patient days must be maintained in a clear and consistent manner for all reporting periods. The detailed record of all patient days must be in agreement with monthly attendance reports and shall be the denominator used in the computation for determining per diem rates providing that said patient days are equal to or greater than 98% of the statewide average occupancy rate of the prior calendar year. In calculating patient days the date of admission is counted as one day, however, the date of death or discharge is not counted as a day.

**AUDIT OF PROVIDER COSTS**

In accordance with 45 CFR-250.30 p.(3) (ii) (B) all cost reports will be desk audited within six months of submission.

The State of Rhode Island, Rate Setting Unit, shall conduct audits of the financial and statistical records of each participating provider in operation.

Audits will be conducted under generally accepted auditing standards and will insure that providers are reporting under generally accepted accounting principles.

Other matters of audit significance which will be undertaken are the examination of construction costs. Costs of new construction may be audited by the State as herein described. Services and affiliated organizations where common ownership exists shall also be subject to audit. The extent of the audits will depend primarily on the relative dollar impact of these service groups.

Audits will include any tests of the provider's records deemed necessary to ascertain that costs are proper and in accordance with Medicaid principles of reimbursement and that personal needs accountability is in compliance with existing regulations. The knowing and willful inclusion on non-business related expenses, non-patient related expenses, or costs incurred in violation of the prudent buyer concept may be subject to criminal and/or civil sanctions. Failure of auditors of the Department to identify the above items or their adjustment of same shall not constitute a waiver of any civil or criminal penalty.

## **OPERATING COSTS**

Property Payment – Fair Rental Value System (FRV)

The property payment effective September 1, 2004 will be a Fair Rental Value System (FRV) which will provide a payment in lieu of the Other Property Related Cost Center. This will eliminate reimbursement for depreciation, interest, rent, and/or lease payments on property, plant and equipment, working capital interest, all other interest, and vehicle depreciation and/or lease payments. The Fair Rental Value System (FRV) establishes a facility's value based on its age. The older the facility, the less its value. Additions and renovations (subject to a minimum per bed limit) and bed replacements will be recognized by lowering the age of the facility and, thus increasing the facility's value. The facility's established value is not affected by sale or transfer and new facilities will be assigned a rate based upon a completed survey. All Fair Rental Value Surveys are subject to field audit.

The Fair Rental Value System payment rate received by a facility as of September 1, 2004 shall be no lower than the Other Property Related Cost Center payment rate received as of June 30, 2004.

The parameters of the Fair Rental Value System and the start up of the system are as follows:

1. The initial age of each nursing facility participating in the Medicaid Program and used in the FRV calculation shall be determined as of September 1, 2004 utilizing a statewide survey to determine each facility's year of construction and date of entry into the Medicaid program. In addition, this age will be reduced for replacements, renovations and/or additions that have occurred since the facility was built.
2. A bed value, based on a standard facility size of 450 square feet per bed, will be

7. The calculated Fair Rental Value (FRV) shall be divided by patient days for the cost reporting period. Patient days are based upon the higher of the actual census or 98% of the statewide average for all facilities included in the Fair Rental Value calculation. For start up of the Fair Rental Value System, this is considered to be calendar year 2002 for FRV rate assignment effective September 1, 2004. For rate calculations July 1, 2005 and subsequent, the census will be predicated on the previous calendar year.
8. The age of each facility will be further adjusted each July 1, to make the facility one year older, up to the maximum age, and to reduce the age for those facilities that have completed and placed into service major renovations, bed additions or replacements.
9. As previously noted, the age of each facility is adjusted for major renovations, bed additions and replacements. These changes will be averaged into the age of the facility the July 1<sup>st</sup> following the year the major renovations were placed in service or year beds were placed in service. Major renovations are defined as a project, or series of projects, with capitalized cost equal to or greater than \$1000. per bed. This is calculated on a calendar year basis.
10. Continued explanation and examples of the Fair Rental Value System (FRV) are as follows:
  - A. Facility of 120 beds, constructed in 1994, with no major renovations or bed additions and occupancy of 95.0%.
 

Value per bed	\$ 66,000.
Number of beds	120.

Value (value per beds x beds)	\$ 7,920,000.
Accumulated Depreciation (1.5% x 10 yrs. = 15.0%)	\$ 1,188,000.
Net Value (value less accumulated depreciation)	\$ 6,732,000.
Land Value (10% x value per bed x # of beds)	\$ 792,000.
Total Value	\$ 7,524,000.
Fair Rental Value Return (total value x 9.0%)	\$ 677,160.
Fair Rental Value Per Diem Rate(41,610 patient days)	\$ 16.27

- B. Example of bed addition – The addition of beds will require a computation on the weighted average age of the facility based on the construction dates of the original facility and the additional beds placed in service.

Facility of 120 beds, constructed in 1994, which added 40 beds in 1999.

Beds	Age	Weighted Average
120	5 (1999-1994)	600
40	0	0
160		3.75

New Base year 1995 (1999 – 3.75)

As compared to 1999

- c. Renovation or major improvement – The cost of major renovations and improvements are factored into a facility's age provided that they meet the definition that it is a project with capitalized cost equal to or greater than \$1,000. per bed. This is based on a calendar year basis. Renovation/improvement cost must be documented through cost reports, depreciation schedules, etc. and are subject to audit. Costs must be capitalized

in order to be considered a renovation or improvement. Individual assets with a cost of \$500.00 or more and a useful life of at least 3 years must be capitalized. Useful lives for assets acquired after September 1, 2004 are determined by utilizing the American Hospital Association (AHA) guidelines of Depreciable Hospital Assets, 1998 edition or subsequent. Assets acquired in quantity at a total cost of \$1,000. or more and multiple purchases of similar individual assets during a reporting period must be capitalized if the useful life is three years or more. In establishing the age of a facility, renovations/improvements are converted into an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility. The equivalent number of new beds will be determined by dividing the project cost by the construction cost of a new bed in the year of the renovation/improvement project. Refer to Appendix 'E' for historical cost data indexes.

**Example :** Facility of 120 beds, constructed in 1994 and had a major renovation project totaling \$1,000,000. in 2000.

Cost of renovation \$1,000,000. divided by replacement cost index in 2000 of \$60,443.  
equals 16.54 beds ( figure cannot exceed total number of beds).

Beds	Age	Weighted Average
16.54	0	0
<u>103.46</u>	6	620.76
120.00		620.76
		5.17

New base year 1995, as compared to 2000.

D. Replacement of Beds – The replacement of existing beds will result in an adjustment